DEPARTMENT OF HEALTH AND HUMAN SERVICES	
CENTERS FOR MEDICARE & MEDICAID SERVICES	

		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E594	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE COMPLETED B. WING (X3) DATE SURVE COMPLETED 03/18/2011			ETED	
	PROVIDER OR SUPPLIER EY HEALTH CARE		B. WIN	STREET A 2907 EA	ADDRESS, CITY, STATE, ZIP CODE AST 136TH STREET EL, IN46033	<u> </u>	
				L CARIVIE	EL, 1146033		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0000	This visit was for State Licensure S	r a Recertification and Survey	F00	00			
	Survey dates: March 14th, 15th, 16th, 17th, and 18th, 2011 Facility Number: 000545						
	Provider Number						
	AIM Number: 10						
	Survey Team: Michelle Hosteter RNTeam Coordinator						
	Janet Stanton, RN						
	Rita Mullen, RN						
	Census bed type:						
	NF27						
	Total27						
	Census Payor Ty	pe:					
	Medicaid26						
	Other1						
	Total27						
	Sample: 10						
	These deficiencie	es also reflect state					
		dance with 410 IAC 16.2.					
	<u> </u>						
	Quality review co	ompleted 3-24-11					
	Cathy Emswiller	•					
LABOR ATOR	Y DIRECTOR'S OR PROV	TIDER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

KPFM11

Facility ID:

000545

If continuation sheet

	OF CORRECTION	IXI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E594	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	COMP	COMPLETED 03/18/2011	
	PROVIDER OR SUPPLIER		STREET 2907 E	ADDRESS, CITY, STATE, ZIP CO AST 136TH STREET EL, IN46033	DE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES SCY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	ECTION DULD BE PROPRIATE	(X5) COMPLETION DATE	

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DUILDING			COMPLE	ETED
		15E594	1	A. BUILDING B. WING)11
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER				AST 136TH STREET		
MCGIVN	EY HEALTH CARE	CENTER			EL, IN46033		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	D BE COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
F0157	Based on record	review and interview, the	F01	57	Disclaimer: Preparation,		04/17/2011
SS=D	facility failed to	notify the physician of			submission and implementation		
00-0	•	ng in a timely manor for			of this Plan of Correction does	not	
		gastric feeding tube. This			constitute an admission of or		
		-			agreement with the facts and conclusions set forth on the		
	•	resident with a gastric			survey report. Our Plan of		
	_	sample of 10. (Resident			Correction is prepared and		
	#15)				executed as a means to		
					continuously improve the qual	ity	
	Findings include	•			of care and to comply with all		
					applicable state and federal		
	The clinical reco	rd of Resident #15 was			regulatory requirements. 1. It		
	reviewed on 3/15/11 at 12:35 P.M.				the policy of McGivney Health		
	Teviewed on 3/13	7/11 at 12.55 1.1v1.			Care Center to immediately no the resident's physician of any	- 1	
	D: C D	.1 . //15 . 1 . 1 . 1			changes in resident's condition		
		esident #15 included, but			Nurses were immediately	10.	
	were not limited	to, dysphasia, cerebral			in-serviced on Physician		
	vascular accident	t, and chronic obstructive			Notification of Changes		
	pulmonary diseas	se.			Condition. Resident # 15 clini		
					record reviewed and a new ord		
	A "Guidelines fo	r Physician Notification			obtained to clarify current g-tul	be	
		ontrition Overview", not			order to read check residual	-l:-	
	_				every shift and PRN. If residu greater than 150ccs withhold t		
	dated, received fi	•			feeding and notify physician.	ube	
		3/18/11, indicated the			Resident # 15 care plan was		
	following:				updated to read: after episode	s of	
					nausea and vomiting nurse to		
	"I. Prompt notific	cation for acute problems			assess amount of residual, lur	ng	
	- These situation	require direct			sounds, bowel sounds, and		
		with the physician and			abdominal distention and	_	
	may not be faxed				documented in the clinical reco		
	-	_			with date and time. 2. An au		
		and laboratory values			of the residents revealed that in other residents were affected by		
		e nurse to notify the			this practice. 3. Nursing	- J	
	1 2	n as possible, either			in-services conducted		
	directly or by bee	eper. If you do not obtain			on: Physician Notification	of	
	a response from	the physician, call the			Changes Condition The		
	_	_ -					

000545

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	15E594		A. BUILDING				
		10004	B. WIN		A DDDDGG GITTU GTATE TID GODE	03/18/2011		
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE AST 136TH STREET			
MCGIVN	EY HEALTH CARE	CENTER		1	EL, IN46033			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TE C	OMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	facility's Guidelines for Physici	an	DATE	
	~	ate physician. If you still			Notification for Changes in	all		
		response, notify the			Condition Administration	n of		
	Medical Director	for further			Enternal Feedings 24hr			
	instructions				Report Log Documentation 4			
					Charge nurses are responsible for notifying the resident's	9		
	A. Symptoms Wa	arranting Prompt			physicians of any change of			
	Notification				condition. All nurses will be			
		plaint or apparent			responsible for documenting of			
	discomfort which				the 24hr Report Log change o condition on residents. The	т		
		n in onset			DON/designee is responsible	for		
	2. Specific examples of new onset symptomsvomiting > 2 times in 24				ongoing monitoring of 24hour			
					Report Log. Nurses failing to			
	hrs"				adhere to the facility policies a			
					procedures will be counseled the DON up to and including	Ју		
	1	lated 1/6/2011 at 6:30			disciplinary action. DON will b	ring		
	· ·	Projectile vomiting at			findings from 24hour Report L			
	` ′	be feeding held for 2 hrs.			to QA weekly.			
	Then restarted. N	No more vomiting [after]						
	4 AM (sic)"							
	A nursing note, d	lated 1/6/11 at 10:00						
		'Pegtube patent,						
	· ·	ed, [no] difficulty [with]						
	1 *	dual noted. Infusing						
	Osmolite 1.5 @ 8	•						
	centimeters)/hr v	•						
	,							
	I -	lated 1/6/11 at 11:00						
		'Feeding held for 2 hours						
	l '	is. HOB (head of bed)						
	[up]"							
	A nursing note, d	lated 1/6/11 at 1:00 P.M.,						

000545

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPL	ETED
		15E594	B. WING			03/18/2011	
			P. (12)		ADDRESS, CITY, STATE, ZIP CODE	1	
NAME OF F	ROVIDER OR SUPPLIER	t .			AST 136TH STREET		
MCGIVN	EY HEALTH CARE	CENTER		1	EL, IN46033		
				<u>.</u>			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	_	e infusing [without] c/o					
	(complaint of) fu	orther emesis at this time.					
	HOB [up]"						
	A nursing note of	dated 1/6/11 (not time					
		"Spoke [with] (name of					
		medical records on a					
		Barium Swallow (MBS).					
	_	vith] [no] records					
		a. MD notified [with] new					
	order received. A	Appt (appointment) made					
	for MBS Son.	made aware" The tube					
	feeding was held	I twice, for 2 hours due to					
	vomiting, but the	e physician was not					
	•	ome time after 1:00 P.M.					
	contacted until 50	one time after 1.00 1.1vi.					
	During a intervie	ew with the Director of					
	_						
	•	5/11 at 9:30 A.M., she					
		sician was called on					
	_	to the MBS and he would					
	have been told at	t that time about the					
	vomiting. This w	as at least two hours					
	_	ed was held the second					
	time due to vomi						
		- U					
	3.1-5(a)(2)						
	3.1-3(a)(4)						

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		15E594	B. WIN	G		03/18/2011	
	PROVIDER OR SUPPLIER		•	2907 E	ADDRESS, CITY, STATE, ZIP CODE AST 136TH STREET EL, IN46033		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X	5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPL	ETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)	DAT	Έ
F0272	Based on record	review and interview, the	F02	72	Disclaimer: Preparation,	04/17/	/2011
SS=D	facility failed to a	assess a resident with a			submission and implementation		
	gastric feeding tu	be, after vomiting, for			of this Plan of Correction does constitute an admission of or	not	
		odominal distention or			agreement with the facts and		
	lung sounds. This				conclusions set forth on the		
	•	ed for feeding tubes in a			survey report. Our Plan of		
		esident #15) The facility			Correction is prepared and		
		ess a resident at high risk			executed as a means to	,,	
		wn. This impacted 1 of 4			continuously improve the quali of care and to comply with all	iy	
		•			applicable state and federal		
	-	ssure in a sample of 10.			regulatory requirements. 1. It	is	
	(Resident#21)				the policy of McGivney Health		
					Care Center to conduct initial	ınd	
	Findings include:				periodic assessments of each		
					resident's functional capability Resident # 15 clinical record		
	1. The clinical re	ecord of Resident #15			reviewed and a new order		
	was reviewed on	3/15/11 at 12:35 P.M.			obtained to clarify current g-tul	oe	
					order to read check residual		
	Diagnoses for Re	esident #15 included, but			every shift and PRN. If residua	I	
	•	to, dysphasia, cerebral			greater than 150ccs withhold t	ube	
		t [stroke], and chronic			feeding and notify physician. Resident # 15 care plan was		
	obstructive pulm				updated to read: after episode	s of	
	23311 active pulling	onary and			nausea and vomiting nurse to		
	Δ Nursing Proces	dure titled "Naso-Gastric			assess amount of residual, lun	g	
	•				sounds, bowel sounds, and		
	• ,	not dated) received from			abdominal distention and	urd	
	· ·	nistrator, on 3/18/11,			documented in the clinical reco		
	indicated the foll	owing:			#21 area on her spine was		
					assessed, measured and		
	"Procedure				documented by nursing staff ir		
					clinical record on the day it wa	I	
	Check abdome	n for distention before			observed. Resident #21's care	;	
	feeding. If disten	ded, listen for bowel			plan was updated to reflect current interventions. 2. Audit	s of	
	sounds throughou	ut lower abdomen. Do			the residents revealed that no	, 51	
	_	if resident indicates any			other residents were affected to	y	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING		COMPLETED	
		15E594	B. WIN			03/18/2011	
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			1	AST 136TH STREET		
MCGIVN	EY HEALTH CARE	CENTER		1	EL, IN46033		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		
TAG		LSC IDENTIFYING INFORMATION)	+	TAG		DATE	
		ion. Residual or retention			this practice. 3. Nursing		
	can lead to regur	gitation or aspiration.			in-service conducted on: Comprehensive Assessments		
					and Detailed Follow-up	·	
	9. Watch the re	esident closely for signs			Administration of Enternal		
		oking, cyanosis, or			Feedings 24hr Report Log		
	regurgitation"	<i>G</i> , <i>-J</i> , <i>01</i>			Documentation 4. All nurses	will	
	i oguigitation				be responsible for documenting	ıg	
	Th. M. 1' 4'	A destrict and the D			on the 24hr Report Log any		
		Administration Record,			residents with G-tubes that ha	ve	
		2011, indicated the			episodes of nausea and vomiting. All nurses will be		
	feeding tube residue	dual amount and			responsible for documenting of	un l	
	placement was checked on 1/6/11 at 6:00				the 24hr Report Log the stagir		
	A.M., 2:00 P.M.	and 10:00 P.M.			measurements and physician	·9,	
					notification of pressure sores.		
	A nursing note of	lated 1/6/2011 at 6:30			The DON/designee is respons	sible	
		'Projectile vomiting at			for ongoing monitoring of 24ho	our	
	· ·				Report Log. Nurses failing to	.	
		be feeding held for 2 hrs.			adhere to the facility policies a		
		No more vomiting [after]			procedures will be counseled the DON up to and including	ру	
		(blood pressure 130/72."			disciplinary action. DON will b	nring	
	The resident was	not assessed for bowel			findings from 24hour Report L		
	sounds, abdomin	al distention or lung			to QA weekly.		
	sounds after vom	iting.			-		
		-					
	A nursing note d	lated 1/6/11 at 10:00					
		'Pegtube patent,					
	· ·	ed, [no] difficulty [with]					
	1 ^						
		dual noted. Infusing					
	Osmolite 1.5 @ 3	-					
	centimeters)/hr v	ia gravity"					
	A nursing note, of	lated 1/6/11 at 11:00					
	A.M., indicated "Feeding held for 2 hours d/t (due to) emesis. HOB (head of bed)						
	[up]" The resident was not assessed for						
	[[up] The resid	dent was not assessed for					
			1		I		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	15E594	A. BUILDING		COMPLETED 03/18/2011	
		100004	B. WING	ADDRESS SITE STREET STREET	03/10/2011	
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE AST 136TH STREET		
	EY HEALTH CARE		I	EL, IN46033		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B		
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
		odominal distention or			DATE	
	lung sounds after					
	rung sounds urter	vointing.				
	A nursing note of	dated 1/6/11 at 1:00 P.M.,				
	indicted "Pegtube infusing [without] c/o					
	_	orther emesis at this time.				
	HOB [up]"					
	F. E.1					
	During an intervi	iew with the Director of				
	Nursing, on 3/16/11 at 9:30 A.M., she					
	indicated she had	d talked to the nurse, that				
	worked that nigh	t, and that the Resident's				
	lungs were listen	ed to after vomiting, She				
	did not indicated	that the abdomen was				
	assessed for bow	rel sounds or distention.				
				1		

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		15E594	B. WIN	G		03/18/2011	
NAME OF F	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					AST 136TH STREET		
MCGIVN	EY HEALTH CARE	CENTER		CARME	EL, IN46033		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		
TAG		LSC IDENTIFYING INFORMATION)	F02	TAG		DATE	
F0272		w during the initial	F02	12	Disclaimer: Preparation, submission and implementation	04/17/2011	
SS=D		on 3/14/11 at 11:30 A.M.,			of this Plan of Correction does	l l	
		ing #4 indicated Resident			constitute an admission of or		
	_	hair for mobility, was			agreement with the facts and		
		e services, had skin tears			conclusions set forth on the survey report. Our Plan of		
	_	ad a Stage I pressure area			Correction is prepared and		
	•	area of her back. The			executed as a means to		
		n order for a "Duoderm"			continuously improve the quali	ity	
	•	nt had recently been			of care and to comply with all applicable state and federal		
	obtained.				regulatory requirements. 1. It	is	
	On 3/14/11 at 11:30 A.M., the resident				the policy of McGivney Health		
					Care Center to conduct initial a	and	
		bed, laying on her back.			periodic assessments of each		
		ing #4 indicated the			resident's functional capability Resident # 15 clinical record		
		ss was the facility's			reviewed and a new order		
	-	re-reducing" mattress-			obtained to clarify current g-tu	be	
	-one that had a fo	oam insert for the area of			order to read check residual		
	_	sident's geri-chair was			every shift and PRN. If residu greater than 150ccs withhold t		
	observed at that t	time to have no			feeding and notify physician.	ubc	
	pressure-relieving	g cushions on the seat or			Resident # 15 care plan was		
	at the back.				updated to read: after episode	s of	
					nausea and vomiting nurse to		
	The clinical reco	rd for Resident #21 was			assess amount of residual, lur sounds, bowel sounds, and	'9	
	reviewed on 3/15	5/11 at 9:15 A.M.			abdominal distention and		
	Diagnoses includ	led, but were not limited			documented in the clinical reco		
	to, dementia, C.V	A. [cerebral vascular			with date and time. Resident	t	
	accident"stroke	"] with right hemiparesis			#21 area on her spine was assessed, measured and		
	[paralysis], anem	ia, hypertension, chronic			documented by nursing staff ir	n	
	pain, and history	of weight loss.			clinical record on the day it wa	as	
					observed. Resident #21's car	e	
	A nurse's "Condi	tion Change Form"			plan was updated to reflect current interventions. 2. Audit	s of	
	progress note, da	ted 3/6/11, indicated			the residents revealed that no		
	"Area to bony pro	ominence of spine."			other residents were affected I	by	

Event ID:

KPFM11 Facility ID:

000545

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIIII	A. BUILDING			ETED
		15E594	B. WIN			03/18/2	011
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	2		1	AST 136TH STREET		
MCGIVN	EY HEALTH CARE	CENTER		1	EL, IN46033		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	There were no pr	revious nurse's progress			this practice. 3. Nursing		
	notes with assess	sment documentation of			in-service conducted on:		
	the resident's mi	d-spine area. On 3/6/11,			Comprehensive Assessments and Detailed Follow-up		
		ained from the attending			Administration of Enternal		
	physician for "D	_			Feedings 24hr Report Log		
		oine. Change every 3			Documentation 4. All nurses		
	days."				be responsible for documenting	g	
	augo.				on the 24hr Report Log any residents with G-tubes that ha		
	A "Braden Scolo	for Predicting Pressure			episodes of nausea and	v c	
	A "Braden Scale for Predicting Pressure Sore Risk" form had entries for 2/27 and				vomiting. All nurses will be		
					responsible for documenting o	n	
		dent scored a "12" on			the 24hr Report Log the stagir		
		on $3/1/11$. The assessment			measurements and physician		
	_	core between 10-12 was			notification of pressure sores.	:bla	
	"High Risk," wit	h a score of 9 or below			The DON/designee is respons for ongoing monitoring of 24ho		
	"Very High Risk	." A "Second			Report Log. Nurses failing to		
	Assessment" not	e, dated 3/1/11 indicated			adhere to the facility policies a	nd	
	"Resident has no	open or red areas.			procedures will be counseled I	ру	
	Pressure reducin	g mattress to bed and			the DON up to and including		
		_					
		-				og	
		_			to QA weekly.		
	is receiving mos	pice services.					
	A care plan entr	dated 2/11/11					
	•						
		,					
		_					
		•					
		-					
	breakdown; Braden's scale quarterly						
	and P.R.N."						
	On 3/18/11 at 10:30 A.M., the resident						
	was observed in	bed for a dressing change					
	Pressure reducing mattress to bed and wheelchair. Turned every 1-2 hours. Heels floated while in bed for no pressure. Is receiving Hospice services." A care plan entry, dated 2/11/11, addressed a problem of "At risk for skin breakdown." The interventions included, but were not limited to, the following: "Monitor skin every shift for signs/symptoms of potential skin breakdown; Braden's scale quarterly and P.R.N."				disciplinary action. DON will be findings from 24hour Report Letto QA weekly.		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED		
THISTERN	or conduction	15E594	- 1	A. BUILDING			111
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			1	AST 136TH STREET		
MCGIVN	EY HEALTH CARE	CENTER	CARMEL, IN46033				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)	-	DATE
	*	the facility consultant					
		attendance. Initially,					
	R.N. #3 identified an area at the resident's						
	· ·	ad a 0.3 cm. [centimeter]					
		rin tear, surrounded by 6					
	_	ea. The coccyx had a					
	•	re. The nurse used a					
	~	slightly lift the skin tear,					
	and commented '	•					
	requested to view the mid-spine area, the nurse said "Oh, yeah," and lifted the						
	·	o. The resident was					
	observed to have	a mile kyphosis					
	[curvature of the	spine]. The area was					
	covered with a D	uoderm dressing, which					
	the nurse remove	ed. A 5 cm.					
	oblong-shaped re	eddened area was					
	observed over the	e bony prominence's of					
	the resident's mic	d-spine area, with a 2 cm.					
	darker circle in the	he center of the area. The					
	skin was not ope	n.					
	During a daily co	onference on 3/18/11 at					
		Administrator and					
	l '	es were given the					
		ovide any assessment					
		reviously completed					
	_	ident's coccyx and					
	mid-spine areas.	,					
	On 3/18/11 at 1:4	45 P.M., R.N. #6					
		of the consultant Wound					
	Nurse's "Wound						
		<i>3</i>					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E594			(X2) MULTIPLE A. BUILDING B. WING	E CONSTRUCTION	I	e survey leted 2011
	PROVIDER OR SUPPLIER		STRE 2907	ET ADDRESS, CITY, STATE, ZIP CODE 7 EAST 136TH STREET RMEL, IN46033		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
	last form was dat the resident's rigl indicated assessn coccyx and mid- the facility nursin On 3/18/11 at 2:1 indicated the resi her spine, and ha at least 30 minute coccyx and mid- blanchable and n resident's coccyx observed to be on A low-air loss sp placed on the bec facility was obtain cushion to be pos	dent had a kyphosis of d been off of her back for es. The areas on the				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIIII	DDIC		COMPL	ETED
		15E594	A. BUII B. WIN			03/18/2	011
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	8		1	AST 136TH STREET		
MCGIVN	EY HEALTH CARE	CENTER		1	EL, IN46033		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΤE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
F0314		ation, interview, and	F03	14	Disclaimer: Preparation, submission and implementation	nn.	04/17/2011
SS=D	· ·	ne facility failed to			of this Plan of Correction does		
	provide pressure	relieving devices in a			constitute an admission of or	1100	
	timely manner fo	or 1 of 4 residents who			agreement with the facts and		
	had pressure sore	es and/or potential open			conclusions set forth on the		
	•	in a sample of 10			survey report. Our Plan of		
	· ·	ed. [Resident #21]			Correction is prepared and		
	residents leviews	ed. [Resident #21]			executed a means to	:4	
	Eindings include				continuously improve the quali of care and to comply with all	ity	
	Findings include	·-			applicable state and federal		
					regulatory requirements. 1. It	is	
	In an interview d	_			the policy of McGivney Health		
	orientation tour of	on 3/14/11 at 11:30 A.M.,			Care Center to provide pressu	ıre	
	Director of Nurs	ing #4 indicated Resident			relieving devices in a timely		
	#21 used a geri-c	chair for mobility, was			manor to prevent pressure sor	es.	
	receiving Hospic	ee services, had skin tears			Resident # 21 did receive a cushion for her back and a low	, oir	
		nad a Stage I pressure area			mattress before the survey tea		
		area of her back. The			exited. Resident #21 area on		
	•	in order for a "Duoderm"			spine was assessed and		
		ent had recently been			measured and documented by	/	
	_	in had recently been			nursing staff in clinical record.		
	obtained.				Resident #21's care plan was		
					update to reflect current		
	The American M				interventions. 2. An audit of the residents revealed that no other		
	Association's "Pi	ressure Ulcers in the			residents were affected by this		
	Long-Term Care	Setting, Clinical Practice			practice. 3. Nursing in-service		
	Guideline" manu	al, copywrite 2008,			conducted on: Immediate		
		I" pressure area as "Intact			Treatments to Prevent/Heal		
	_	anchable redness of a			Pressure Sores and Detailed		
		sually over a bony			Follow-up The facility's new Policy and Procedure for Brad	on	
	•	The area may be painful,			Scale, Skin Assessments and		
	-				Providing Pressure Relieving	'	
		er or cooler as compared			Devices in a Timely Manor 2	24hr	
	-	e May indicated "at			Report Log Documentation 4		
	risk" persons (he	eralding sign of risk)."			All nurses will be responsible f		
					documenting on the 24hr Repo	ort	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPL	ETED	
		15E594	B. WIN			03/18/20	011	
			p. ,, 11		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIER			1	AST 136TH STREET			
MCGIVN	EY HEALTH CARE	CENTER			EL, IN46033			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	On 3/14/11 at 11:30 A.M., the resident was observed in bed, laying on her back.				Log any new pressure sores, to interventions that were	sores, the		
		ing #4 indicated the			implemented. The	e for		
		ss was the facility's			DON/designee is responsible ongoing monitoring of 24hour	TOr		
		re-reducing" mattress-			Report Log. Nurses failing to			
	_	oam insert for the area of			adhere to the facility policies a	ınd		
					procedures will be counseled			
	I -	dicated she had contacted			the DON up to and including			
	· ·	ncy the previous Friday to			disciplinary action. DON will be	٠ ١		
	_ ^	ty pressure-relieving			findings from 24hour Report L	og		
		lay, and was told the			to QA weekly.			
	agency did not p	rovided a low-air loss						
	mattress unless a	resident already had a						
	Stage III pressure	e sore.						
	The resident's ge	ri-chair was observed at						
	that time to have	no pressure-relieving						
	cushions on the s	seat or at the back.						
		:35 A.M., the resident						
	was observed in	•						
	room/activity roo	om. She was wheeled						
	into the area by t	he beautician, and placed						
	at a table in front	t of the T.V. The resident						
	was sitting on a c	cushion in the seat of the						
	_	nd no cushion or other						
	-	g device for her back and						
	spine.							
	Spine.							
	On 3/17/11 at 9:3	30 A.M., the resident was						
		, , , , , , , , , , , , , , , , , , ,						
	observed in the main dining room. There was a pressure-relieving cushion on the							
	_	_						
	seat of the geri-c							
	pressure-relievin	g device behind her back.						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING		COMPL	ETED
		15E594	B. WIN			03/18/2	011
		1	D. 1111		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			AST 136TH STREET		
MCGIVN	EY HEALTH CARE	CENTER		1	EL, IN46033		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	The resident's be	ed was observed to have					
	the same standar	d "pressure-reducing"					
	foam insert matt	ress.					
	On 3/18/11 at 10	30 A.M., the resident					
		bed for a dressing change					
		the facility consultant					
	1 *	•					
		attendance. Initially,					
		ed an area at the resident's					
	1	ad a 0.3 cm. [centimeter]					
		kin tear, surrounded by 6					
	1	rea. The coccyx had a					
	roughened textur	re. The nurse used a					
	gloved finger to	slightly lift the skin tear,					
	and commented	"It's dry." When					
	requested to view	w the mid-spine area, the					
	_	yeah," and lifted the					
		p. The resident was					
		e a mile kyphosis					
		spine]. The area was					
	I -	Duoderm dressing, which					
		•					
	the nurse remove						
		eddened area was					
		e bony prominence's of					
		d-spine area, with a 2 cm.					
	darker circle in t	he center of the area. The					
	skin was not ope	en.					
	The resident was	s observed to be laying on					
		ndard pressure-reducing					
	· ·	eri-chair had the seat					
	_	device for the back. The					
	1	bserved to have a stiff					
	gen-chan was of	userveu to have a still					

PRINTED: 04/11/2011 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		15E594	B. WIN			03/18/2	011	
NAME OF F	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE			
				1	AST 136TH STREET			
	EY HEALTH CARE				EL, IN46033			
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION	
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	JΈ	DATE	
		covering the hard		_				
	1 ' '	underneath. In an						
		time, Director of Nursing						
		would call the Hospice						
	agency to see abo	out obtaining a specialty						
	mattress and a cu	ishion for the resident's						
	1	ed later at 11:00 A.M.						
	1	agency had criteria for						
	~	n they would provide						
	specialty mattres							
	l *	g devices, but would						
		loss mattress for the						
	resident.							
	In an interview o	n 3/18/11 at 11:00 A.M.,						
		r indicated she had not						
	known about the	resident's skin areas.						
	She indicated the	e facility did, in fact, have						
	it's own low-air l	oss mattress which was						
	not currently in u	ise by any other resident,						
	and that it would	be placed on the						
	resident's bed im	mediately.						
	On 2/10/11 -4 2:1	15 D.M. D.N. 44						
	On 3/18/11 at 2:1	dent had a kyphosis of						
		d been off of her back for						
	_	es. The areas on the						
	coccyx and mid-							
	l '	o longer reddened. The						
		and mid-spine area were						
	l -	nly slightly pink in color.						
		ecialty mattress had been						
	_	d. R.N. #6 indicated the						

000545

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		15E594	A. BUI B. WIN			03/18/2	
NAME OF F	PROVIDER OR SUPPLIER		!	STREET A	ADDRESS, CITY, STATE, ZIP CODE	ļ.	
MCGIVN	EY HEALTH CARE	CENTER		1	AST 136TH STREET EL, IN46033		
(X4) ID		TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	πE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
ı	facility was obtaining a pressure-relieving cushion to be positioned at the resident's back when she was up in the geri-chair.						
		rd for Resident #21 was					
	reviewed on 3/15						
	"	led, but were not limited /.A. [cerebral vascular					
	l '	"] with right hemiparesis					
		iia, hypertension, chronic					
	pain, and history	of weight loss.					
	The Merch 2011	nhygiaian ardar ragan					
	· ·	physician order recap heet listed an order,					
	dated 9/25/09, fo						
	· ·	atin/Zinc 1:1:1apply					
	1 * *	cks/sacrum daily P.R.N.					
	[as needed]."						
ı	A nurse's "Condi	tion Change Form"					
		ted 3/6/11, indicated					
	1	ominence of spine."					
	1	revious nurse's progress					
		nentation of the resident's					
	_	On 3/6/11, an order was e attending physician for					
		ny prominence of spine.					
	Change every 3 of						
	A44 1* 1	atatanta andan 1771					
		vsician's order, dated d "To have pressure					
	· ·	ty mattress second to					
	ı	ne. Hospice to provide."					

000545

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING		COMPL		
		15E594	B. WIN			03/18/2	011	
NAME OF F	DROLUDED OD GUDDU IED			STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF F	PROVIDER OR SUPPLIER			2907 EA	AST 136TH STREET			
	EY HEALTH CARE			<u>l</u> .	EL, IN46033		(X5)	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION			
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) The resident was admitted to Hospice care on 2/15/11.			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE.	COMPLETION	
TAG				TAG	DETCIENCT)		DATE	
		for Predicting Pressure						
		had entries for 2/27 and						
		dent scored a "12" on						
	l '	n $3/1/11$. The assessment						
	*	core between 10-12 was						
	"High Risk," wit	h a score of 9 or below						
	"Very High Risk	." A "Second						
	Assessment" not	e, dated 3/1/11 indicated						
	"Resident has no	open or red areas.						
	Pressure reducing	g mattress to bed and						
		ned every 1-2 hours.						
		ile in bed for no pressure.						
	Is receiving Hosp	•						
		y 100 501 (1005).						
	One care plan en	try, dated 2/11/11,						
		lem of "Incontinent of						
	_	er" One of the						
		s listed as "Monitor and						
		ition every shift for						
		ation/open areas. Alert						
		•						
	_	bserved for physician						
		otain treatment orders as						
	needed."							
	A41							
		n entry, dated 2/11/11,						
		lem of "At risk for skin						
		e interventions were						
		tor skin every shift for						
	signs/symptoms	•						
	breakdown; pr	ressure reduction device:						

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			A. BUILDING			COMPLETED	
		15E594	B. WI			03/18/2	011
	PROVIDER OR SUPPLIER		•	2907 EA	DDRESS, CITY, STATE, ZIP CODE AST 136TH STREET L, IN46033	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	on chair when up every 1-2 hours; bed linens clean, every shift; offer [resident] to constant position direct side-lying position of bed at lowest of possible; apply pon heel(s) when exposure to hot we cleansing agent a minimize irritation use positional dewedges) to keep direct contact with scale quarterly are	ident's name] in bed and by turn and reposition keep skin clean/dry and dry and wrinkle free fluids and encourage sume; diet as ordered; do etly on trochanter when on used. Maintain head degree of elevation illows to relieve pressure in bed/chair; avoid water and use mild and gentle touch to on and dryness of skin, vices (e.g. pillows, foam bony prominence's from th one another; Braden's and P.R.N." Another was added for "gerid."					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		DDIG		COMPLETED
		15E594	A. BUII B. WIN			03/18/2011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIEF	₹			AST 136TH STREET	
MCGIVN	EY HEALTH CARE	CENTER		1	EL, IN46033	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	1	ID	NEOWINERS N. AN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	DATE
F0372	Based on observ	ation and interview, the	F03	72	Disclaimer: Preparation,	04/17/2011
SS=A	facility failed to	ensure the facility			submission and implementation	
33-A	_	be closed in order to			of this Plan of Correction does	not
	•	spillage of trash, for 1 of			constitute an admission of or	
					agreement with the facts and conclusions set forth on the	
	I dumpster that s	served the facility.			survey report. Our Plan of	
					Correction is prepared and	
	Findings include	:			executed as a means to	
					continuously improve the qual	ity
	On 3/14/11 at 10	0:00 A.M., the facility			of care and to comply with all	
		oserved positioned on the			applicable state and federal	
	•	the parking lot, at the			regulatory requirements. 1. Ti	he
	* *				facility immediately contacted	
		building. The front			Republic dumpster service for	•
	_	open, both rear sliding			replacement dumpster which with delivered during the night with	
	•	e open, and half of the			24hrs. 2. The facility only has	
	hinged top cover	was missing. Plastic			one dumpster. 3. Dumpster w	l l
	bags of trash we	re observed stacked inside			put on the maintenance daily	
	up to the top of t	he dumpster.			check sheet for the maintenan	ice
	r	P			staff to be responsible for visu	ally
	On 3/14/11 at 12	2:00 and 1:00 P.M., the			observing and ensuring the	
					dumpster is in proper working	
	-	eserved with the front			order every business day. 4.	
	_	the two rear sliding panel			Maintenance will be responsibe for visually observing and	oie
	*	position. Half of the			ensuring the dumpster is in	
	hinged top cover	was missing.			proper working order every	
					business day. Maintenance w	vill
	On 3/15/11 at 8:4	45 and 11:15 A.M., the			be responsible for documenting	•
		eserved with the front and			on their Maintenance Daily Ch	
	-	d, but half of the hinged			sheet. Maintenance will	
		•			immediately notify Administrat	or
	top cover was sti	iii missing.			of any problems with the	
					operation of the dumpster.	
	In an interview of	luring the environmental				
	tour on 3/15/11 a	at 1:00 P.M., the				
	Maintenance Sur	pervisor indicated the				
		would have emptied the				
		P 3-2-3, 3-2-2				

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		15E594	A. BUII B. WIN			03/18/2	011
NAME OF F	PROVIDER OR SUPPLIER		•		ADDRESS, CITY, STATE, ZIP CODE AST 136TH STREET	•	
MCGIVN	EY HEALTH CARE	CENTER		1	EL, IN46033		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TF	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0.450	probably broken interview at the s Administrator indexperience previous company that was dumpster, and the have them replace 3.1-21(i)(5)	dicated the facility had bus problems with the s contracted to empty the at she would call and e the dumpster.	F04	5 0	F 458 Resident Rooms We a	20	04/17/2011
F0458 SS=D	interview, the fact bedrooms measure per resident, in 2 Rooms #1 and Rooms #1 at 10:10 provided a compasheet" form. The room #1 was a Normal it had 2 resident was also a NF/Ti had 3 resident bed During the environt at 1 P.M., Room	trance conference on A.M., the Administrator leted "Bed Inventory form indicated resident F/Title 19 certified bed lent beds; and Room #5 tle 19 certified bed and it	F04	58	requesting a variance for the room size of room 1 and room as they meet the needs of the residents and do not create a hazard to the safety of the residents. Please see the enclosed letter requesting a rowaiver approval from Ms. Rhoades, Director of Long Ter Care of ISDH. Gibault Care Ir is responsible for the finding.	oom m	04/17/2011

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E594		(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION	COMPL	(X3) DATE SURVEY COMPLETED 03/18/2011	
	PROVIDER OR SUPPLIER		STREET A 2907 E	ADDRESS, CITY, STATE, ZIP CODE AST 136TH STREET EL, IN46033	3	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETION DATE
		#5 was observed to have with only one currently				
	Administrator in remodeled Room prepared to send Department of H discontinue the r the paper had no ISDH. The adm they intended to Room #5, but ha The measurement follows: *Room #1- 149.square feet per research.	dealth [ISDH] to soom waiver. However, to yet been submitted to inistrator also indicated remove one bed from done so yet. Attraction to the solution of the				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		15E594	B. WIN			03/18/20	011
	PROVIDER OR SUPPLIER		-	2907 E	ADDRESS, CITY, STATE, ZIP CODE AST 136TH STREET EL, IN46033		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	_	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	_	DATE
F0514	Based on record	review and interview, the	F05	14	Disclaimer: Preparation,		04/17/2011
SS=E	facility failed to	ensure that 4 of 7			submission and implementatio		
00 L	residents receivir	ng psychoative			of this Plan of Correction does constitute an admission of or	not	
	medications, had	• 1 •			agreement with the facts and		
	· ·	f behaviors, P.R.N.			conclusions set forth on the		
	psychoactive me				survey report. Our Plan of		
	1 2	ical interventions prior to			Correction is prepared and		
		R.N. psychoactive			executed as a means to	, l	
		survey sample of 10			continuously improve the quali of care and to comply with all	ly	
	residents.	survey sample of 10			applicable state and federal		
		2 414 1 401			regulatory requirements. 1. It	is	
	[Resident #2, #33	3, #14 and #9]			the policy of McGivney Health		
					Care Center to provide each		
	Findings include:				resident with a complete,	.	
					accurate, accessible organized clinical record. All nurses were		
	1. On initial tour	on 3/14/11 at 10:15			in-serviced on the facility's		
	A.M., DON #4 i	ndicated that Resident #2			Behavior Documentation and r	new	
	had behaviors, w	as cognitively impaired,			Policy and Procedure for		
	received psych m	neds and was not			Behavior Documentation to		
	interviewable.				ensure the clinical records for	,	
					residents # 2, #9, #14, and #33 would project consistent	·	
	The clinical reco	rd for Resident #2 was			documentation, and ensure the	at	
	reviewed on 3/16	5/11 at 10:45 A.M.			all nonpharmocological		
		led, but were not limited			interventions were utilized prio	r to	
	_	h delusional features,			P.R.N.s. 2. An audit was	4,_	
		y, and depression.			conducted on all other residen receiving P.R.N.s for behaviors		
	psychosis, anxiet	y, and depression.			were reviewed by QA and	°	
					individual adjustments made a	s	
	The controlled -	shatanaa maaand far			appropriate. 3. Nursing in-ser	vice	
		abstance record for			conducted on: Behavior		
		Ativan 0.5 mg P.R.N.			Documentation The facility's r Policy and Procedure for	iew	
		ident had received			Behavior Documentation 24	_{hr}	
	medication on fo	_			Report Log Documentation A		
	12/14/10- 9:30 P				Staff in-service conducted on:		
	12/29/10 -9 A.M				Behavior Documentation 4.		

000545

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	15E594	A. BUILDING		03/18/2011	
			B. WING		03/10/2011	
NAME OF F	ROVIDER OR SUPPLIER		l	T ADDRESS, CITY, STATE, ZIP CODE		
MCGIVN	EY HEALTH CARE	CENTER	I	EAST 136TH STREET MEL, IN46033		
(X4) ID		TATEMENT OF DEFICIENCIES	ID ID	+	(X5)	
PREFIX		CY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION	
TAG	`	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
	12/30/10- 12			Charge nurses are responsibl	•	
	1/5/11- 10A			for consistently documenting	•	
	1/7/11-5P			nonpharmocological intervent prior to using P.R.N.s. on the	ions	
	1/8/11-8:15A			Behavior Monthly Flow Recor	d,	
	1/12/11-9A			MAR and documenting any		
	1/13/11 - 9A			narratives on the Behavior Notes. All nurses will be		
	1/21/11-9P			responsible for documenting of	on	
	1/22/11-9:30A			the 24hr Report Log any		
	1/23/11-9A			utilization of P.R.N. psychoac		
	1/23/11- 1P			medications SSD/designee wiresponsible for behavior audit	•	
	1/28/11- 1P			each business day and bring	5	
	1/29/11-1:30 P			findings to QA weekly. Nurse	s	
	2/4/11- 8A			failing to adhere to the facility		
	2/4/11- 6:30 P			policies and procedures will b counseled by the DON up to a		
	2/5/11- 11P			including disciplinary action.	•	
	2/6/11- 9A			other staff is required to document on the Behavior		
	Behavior logs we	ere reviewed for		Monthly Flow Record and		
	_	January 2011, February		interventions they tried with resident and document any		
	2011, and March	2011. The behaviors		narratives on the Behavior No	ites	
	being monitored	were: Agitation,				
	insomnia, yelling	c/cursing, and delusions.				
	_	-				
	The behavior log	for December showed				
	that the resident l	had episodes of				
	agitation/yelling	and cursing on 12/3/10 in				
	the evening and	12/9/10 in the evening.				
		ng marked for behavior				
		nnia, and the 12/1/10 was				
		and nights regarding				
		[example] thinking car is				
	here +[and] can o	drive home)"				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E594		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/18/2011		
	PROVIDER OR SUPPLIER		2907 E	ADDRESS, CITY, STATE, ZIP CODE AST 136TH STREET EL, IN46033	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
	record] for Dece 12/14/10 at 9:50 received Ativan	hours as needed for				
	showed that the roof agitation on 1/2 cursing behavior for days and even nights, 1/22/11 during nights and she displayed this	resident had one episode /8/11. For yelling and: 1/5/11 for days, 1/9/11 mings, on 1/20/11 during uring nights, 1/27/11 d 1/30/11 during evenings s behavior. For ior the sheet was blank.				
		January 2011 indicated .N. Ativan on 1/28/11, given.				
	indicated the residual indicated the residual indicated the residual indicated the residual indicated the following the day on: 2/8/a	If for February 2011 dent had agitation on The resident had insomnia ollowing dates: 2/7, 2/10, 2/18, 2/27, and 2/28. The fing and cursing during and 2/15. For the evening hights 2/3 and 2/28.				
	received P.R.N.	O11 M.A.R. indicated she Ativan on 2/5/11 at 10 at 9 A.M. and 2/14 at				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E594		(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION	(X3) DATE SURVEY COMPLETED 03/18/2011		
	PROVIDER OR SUPPLIER		2907 E	ADDRESS, CITY, STATE, ZIP CODI AST 136TH STREET EL, IN46033	E	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPP DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	document titled '	e was documentation on 'P.R.N. Medication /11 at 10 P.M., 2/14 at tivan.				
	For March 2011, sheets were blan	all of the behavior k as of 3/16/11.				
	Ativan had been P.R.N. Medication indicated she rec	R. indicated no P.R.N. given. However, the on tracking form eived medication on . as well as 3/6/11 at 9				

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	LIA (X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIIII	ILDING		COMPLETED	
		15E594	B. WING			03/18/20	011
			l		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			2907 E	AST 136TH STREET		
	EY HEALTH CARE				EL, IN46033		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL	CROSS-REFEREN		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	re	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG			DATE
F0514		w during the initial	F05	14	Disclaimer: Preparation, submission and implementation	.n	04/17/2011
SS=E		on 3/14/11 at 11:45 A.M.,			of this Plan of Correction does		
	Director of Nursi	ing #4 indicated Resident			constitute an admission of or		
	#33 expressed fre	equent somatic			agreement with the facts and		
	complaints, want	ed her family "here all			conclusions set forth on the		
	the time," and ha	d been described by her			survey report. Our Plan of		
	family as having	-			Correction is prepared and executed as a means to		
		ety, and "controlling"			continuously improve the quali	_{itv}	
	behaviors.	,,			of care and to comply with all		
	ociaviois.				applicable state and federal		
	The clinical record for Resident #33 was reviewed on 3/15/11 at 1:45 P.M.				regulatory requirements. 1. It		
					the policy of McGivney Health		
					Care Center to provide each		
	_	led, but were not limited			resident with a complete, accurate, accessible organized	,	
		depression, and general			clinical record. All nurses were		
	anxiety disorder.				in-serviced on the facility's		
					Behavior Documentation and i	new	
	The March, 2011	physician order recap			Policy and Procedure for		
	[recapitulation] f	orm listed medications			Behavior Documentation to		
	of: Xanax [an an	ti-anxiety mediation]			ensure the clinical records for residents # 2, #9, #14, and #3	,	
	0.25 mg. [milligr	rams] one routinely at			would project consistent	٠	
	1:00 P.M., Buspi	rone [Busparan			documentation, and ensure the	at	
	_	ication] 15 mg. routinely			all nonpharmocological		
	twice a day, and				interventions were utilized prior	r to	
	•	PAPa pain medication]			P.R.N.s. 2. An audit was	,,	
		ely three times a day. In			conducted on all other residen receiving P.R.N.s for behavior		
		up listed an order for			were reviewed by QA and	~	
	· ·	*			individual adjustments made a	ıs İ	
	_	one three times a day			appropriate. 3. Nursing in-ser		
	P.R.N. [as needed	aj.			conducted on: Behavior		
					Documentation The facility's r	new	
		:25 A.M., R.N. #6			Policy and Procedure for Behavior Documentation 24	.hr	
	provided a form	titled "P.R.N. Medication			Report Log Documentation A		
	Tracking." She indicated this form was				Staff in-service conducted on:		
	used to documen	t non-pharmacological			Behavior Documentation 4.		
		- 					

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING		COMPL	ETED
		15E594	B. WIN			03/18/2	011
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8		1	AST 136TH STREET		
MCGIVN	EY HEALTH CARE	CENTER		1	EL, IN46033		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	· `	ICY MUST BE PERCEDED BY FULL		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE
IAU		LSC IDENTIFYING INFORMATION)	+	IAU	Charge nurses are responsible		DATE
	interventions atte				for consistently documenting a		
		P.R.N. medication. She			nonpharmocological intervention		
	indicated a form				prior to using P.R.N.s. on the		
		rention Monthly Flow			Behavior Monthly Flow Record	l,	
	Record" was use	ed to document behaviors			MAR and documenting any		
	specific to psych	otropic medications that			narratives on the Behavior		
	were prescribed	for a resident.			Notes. All nurses will be responsible for documenting o	ո	
					the 24hr Report Log any		
	Comparison of the	he "Controlled Substance			utilization of P.R.N. psychoact		
	· •	t sheets for the P.R.N.			medications SSD/designee wil		
	Xanax, the M.A.				responsible for behavior audits	3	
	Administration Record], and the "P.R.N.				each business day and bring findings to QA weekly. Nurses	,	
		king" records for			failing to adhere to the facility	'	
		licated the Xanax was			policies and procedures will be	,	
		ocumented as follows:			counseled by the DON up to a		
	inconsistently uc	ocumented as follows.			including disciplinary action. A	MI	
	D 1 2010	(1 C/I DDN			other staff is required to		
	I	: 6 doses of the P.R.N.			document on the Behavior Monthly Flow Record and		
		umented as signed out on			interventions they tried with		
		Substance Record."			resident and document any		
	1	2 entries on the M.A.R			narratives on the Behavior Not	tes	
	-both of which n	natched an entry on the					
	"Controlled Subs	stance Record." The					
	"P.R.N. Tracking	g" record only listed 3					
	dates for attempt	ting non-pharmacological					
	interventions pri	or to administering the					
	_	e of those dates [12/7/10					
		id not match a date on the					
	I =	stance Record," but did					
	match an entry o	·					
	 January 2011: 1	18 doses of the P.R.N.					
	•	umented as signed out on					
		_					
	uie Controlled	Substance Record."					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E594		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/18/2011		
	PROVIDER OR SUPPLIEF		2907 E	ADDRESS, CITY, STATE, ZIP CODE AST 136TH STREET EL, IN46033	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
	dates for each of the "Controlled Second," and the "Controlled Second," and the "February, 2011: Xanax were doct the "Controlled Second There were only administration of dates for administration of dates for administration of the "P.R.N. Technology of the "P.R.N. Technology of the P.R. documented as second Technology of the P.R. documented as second the "P.R. of the property of the "P.R. of the "P.R. of the property of the propert	the M.A.R., and the the 6 matched entries on Substance Record." Tries on the "P.R.N. I, only 4 of which entrolled Substance M.A.R. 19 doses of the P.R.N. Immented as signed out on Substance Record." 11 entries for entre M.A.R., and the estration of each of the 11 on the "Controlled d." There were 8 entries racking" record, only 7 of both the "Controlled d" and the M.A.R. I through 3/16/11]: 9 N. Xanax were igned out on the stance Record." There on the M.A.R., and that on the "Controlled d." There were 6 entries racking" record, all of entries on the "Controlled d." There were 6 entries racking" record, all of entries on the "Controlled d." There were 6 entries racking" record, all of entries on the "Controlled				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E594		(X2) MULTIPLE C A. BUILDING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/18/2011			
	PROVIDER OR SUPPLIER		2907 E	ADDRESS, CITY, STATE, ZIP CODE EAST 136TH STREET EL, IN46033	00/10/2		
(X4) ID PREFIX	SUMMARY S	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRODEFICIENCY)	OPRIATE	DATE	
IAU	Record" form for December, 2010, 2011 listed target "Depressed/With and "Increased A Wringing of Han forms were blank of behaviors. The March, 2011 Monthly Flow R Xanax listed a ta "Anxiousness." documented on to 13, 14, 15, and 13/7 and 9/11. In an interview of the Administrator they had become the various documedications, and Behavior Commitmitiated. In an interview of the Director of North intervention "Behavior/Intervention" Record" could be "P.R.N. Tracking"	the Xanax for January and February, seed behaviors of drawn," "Anxiousness," enxiety, i.e. Fidgeting, ds," respectively. The for any documentation "Behavior/Intervention ecord" form for the regeted behavior of Episodes were the evening shift for 3/12, 6, and the night shift for many documentation of behaviors, interventions. A weekly sittee meeting had been in 3/17/11 at 9:20 A.M., fursing #5 indicated any	IAG			DATE	
	_	rm completed, and had					

		IDENTIFICATION NUMBER:	A. BUILDING	JNSTRUCTION	COMP	(X3) DATE SURVEY COMPLETED	
		15E594	B. WING		03/18/2	2011	
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODI	3		
	EY HEALTH CARE			AST 136TH STREET EL, IN46033			
				EL, IN40033		.	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU	TION LD BE	(X5) COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPR DEFICIENCY)	ROPRIATE	DATE	
	been doing a lot						
	8	ζ.					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		15E594	B. WIN			03/18/2	011
			P. (12)		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIER	S.			AST 136TH STREET		
MCGIVN	EY HEALTH CARE	CENTER			EL, IN46033		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	-	DATE
F0514	3. The clinical re	ecord of Resident #9 was	F05	14	Disclaimer: Preparation,		04/17/2011
SS=E	reviewed on 3/17	7/11 at 9:10 A.M.			submission and implementation		
00-L					of this Plan of Correction does	s not	
	Diagnoses includ	led, but were not limited			constitute an admission of or agreement with the facts and		
	_	pression, schizophrenia			conclusions set forth on the		
		pression, semzopinema			survey report. Our Plan of		
	and dementia.				Correction is prepared and		
					executed as a means to		
	A nursing note, of	lated 12/28/10 at 8:00			continuously improve the qual	ity	
	P.M., indicated "	Resident following male			of care and to comply with all		
	CNA (certified n	ursing assistant) around			applicable state and federal		
	`	ou, I know you want me			regulatory requirements. 1. It		
		ed him down the long			the policy of McGivney Health		
					Care Center to provide each resident with a complete,		
	-	go into another resident's			accurate, accessible organize	. П	
		e CNA was assisting this			clinical record. All nurses wer		
	resident (sic). Sh	e has been telling staff			in-serviced on the facility's	Ŭ	
	she is pregnant a	nd naming two different			Behavior Documentation and	new	
	male residents. V	When she is told by staff			Policy and Procedure for		
		are in-appropriate she			Behavior Documentation to		
		nen she gets mad and tries			ensure the clinical records for		
	-	_			residents # 2, #9, #14, and #3	3	
	to fall on the floo	or."			would project consistent		
					documentation, and ensure th	at	
	A "Behavior/Inte	ervention Monthly Flow			all nonpharmocological interventions were utilized price	, to	
	Record", dated for	or the months of January			P.R.N.s. 2. An audit was	, iO	
	2011 through Ma	arch 2011, indicated			conducted on all other residen	_{nt's}	
	•	being monitored for			receiving P.R.N.s for behavior		
		g and tearfulness. The			were reviewed by QA and		
	behavior monitor				individual adjustments made a	as	
					appropriate. 3. Nursing in-ser	vice	
	indicated the foll	lowing:			conducted on: Behavior		
	T 2011				Documentation The facility's r Policy and Procedure for	iew	
	January 2011				Behavior Documentation 24	_{Lhr}	
					Report Log Documentation		
	Delusion of bein	g pregnant - 1/2/11. This			Staff in-service conducted on:		
	was not noted in	the nursing notes.			Behavior Documentation 4.		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	15E594	A. BUI	LDING		03/18/2011	
		13034	B. WIN			03/10/20	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
MCGIVN	EY HEALTH CARE	CENTER			AST 136TH STREET EL, IN46033		
					I		(7/5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	· `	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	DATE
TAG	Tearful - 0 Cursing - 1/21/11 the nursing notes February 2011 Delusion regardin Nursing notes inditimes. Yelling - 2/22/11 this behavior 2/2 Tearful - 2/24/11 indicate the beha 2/24/11. March 2011 Delusion - 0 Yelling - 0. Nurs behavior two time Agitation - 0 Tearfulness - 0 4. The clinical references	1. This was not noted in s. Ing a boyfriend - 3 times. dicated this behavior four In Nursing notes indicated 3/11. In Nursing notes did vior of tearfulness		TAG	Charge nurses are responsible for consistently documenting a nonpharmocological interventiprior to using P.R.N.s. on the Behavior Monthly Flow Record MAR and documenting any narratives on the Behavior Notes. All nurses will be responsible for documenting of the 24hr Report Log any utilization of P.R.N. psychoact medications SSD/designee will responsible for behavior audits each business day and bring findings to QA weekly. Nurses failing to adhere to the facility policies and procedures will be counseled by the DON up to a including disciplinary action. A other staff is required to document on the Behavior Monthly Flow Record and interventions they tried with resident and document any narratives on the Behavior Not	e all oons d, n ive li be s s e nd	DATE

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E594		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		COMPI	(X3) DATE SURVEY COMPLETED 03/18/2011		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2907 EAST 136TH STREET CARMEL, IN46033				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	O BE	(X5) COMPLETION DATE	
	~						
	Record", dated for 2011 through Ma Resident #14 wa	•					
	January 2011						
	Combative - January 9, 15, 19, 27 and 30, 2011. Nursing notes indicted Resident #14 was combative January 2, 15, 19, 27, 30 and 31, 2011.						
	-	7 9, 16 and 30, 2011. dicated the Resident was 6 and 30, 2011.					
	February 2011						
	Nursing notes in	ruary 8 and 20, 2011. dicated the Resident was ary 17 and 18, 2011.					
	March 2011						
	Combative - Man	rch 3, 7, 10 and 16, 2011.					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ANDILAN	or correction	15E594	A. BUILDING	03/18/2011	
			B. WING STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER		l l	AST 136TH STREET	
MCGIVN	EY HEALTH CARE	CENTER	CARME	EL, IN46033	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE
		dicated the Resident was			
	combative March				
	3.1-50(a)(1)				
	3.1-50(a)(2)				